

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

-60-035453
STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 5703 Registrar's No. 173

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Child-Medecine Twp</u> Length of stay in 1b <u>Lifetime</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6 1/4 Mi. N.E. Child</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>LIVINGSTON</u> c. CITY OR TOWN <u>Child</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R#2 - 6 1/4 Mi. N.E. Child</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Nesl</u> Last <u>Transue</u>		4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10 1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>4</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Linn County MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John M Transue</u>		13b. MOTHER'S MAIDEN NAME <u>Hattie May Labor</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Navy W.W.I.</u>		16. SOCIAL SECURITY NO. <u>496-42-2633</u>		17. INFORMANT <u>Mrs. R. Transue</u> Address <u>Child MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of stomach with pyloric obstruction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>July 19 1960</u> to <u>Sept 19 1960</u> and last saw ^{her} him live on <u>Sept 16 1960</u> Death occurred at <u>12:05 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>John R. Dunbar M.D.</u> (Degree or title)			22b. ADDRESS <u>Bushfield Mo</u>		22c. DATE SIGNED <u>9-20-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/21/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheeler Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wheeler</u> (State) <u>MO</u>	
24. FUNERAL DIRECTOR <u>E.J. Robertson Funeral Home Child</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>Sep 20, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 13 1960

Pixons

OCT 5 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. M. Roketson

Licensed Embalmer No. 4388
P. O. Address Laredo, Tex.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.